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‘THEY CALL US KILLERS’: AN EXPLORATION OF HERBAL, SPIRITUAL AND WESTERN MEDICAL PRACTICES IN MOMBASA, KENYA

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Abstract

Background: This paper attempts to describe the multi-dimensional perceptions of *mganga/waganga* (Kiswahili: traditional healers) by members of their constituencies, patients, government health officials and religious leaders in Mombasa, Kenya. It also seeks to investigate how these conceptions and perceptions influence the relationships between traditional healers and other stakeholders in the delivery of public healthcare services in Mombasa.

Materials and Methods: A qualitative approach consisting of in-depth interviews and focus group discussions was employed and 43 research participants were interviewed during the period of two months in the summer of 2010. Data were recorded (video and audio), transcribed, and analyzed using the constant comparison method.

Results: Findings indicate that varied opinions and interpretations of *mganga* influence both the decision-making process of the patient and the provision of healthcare by the healer. High tensions exist between *mganga* and other actors, and furthermore, such perceptions seem to evidence themselves in the government’s support for *waganga*, as well as the delineation of healthcare services—whereby certain stakeholders and participants are relegated to specific tasks.

Conclusions: This research builds upon the growing body of knowledge on how African patients—in general and Kenya in particular—and healers inhabit a multifaceted arena of healing in order to effectively negotiate their positions and needs to make complex decisions involving care, contingent upon local economic, social, cultural, and religious factors.

Key words: traditional healing, complementary medicine, spiritual healing, Kenya

Introduction

The practice of medicine continues to evolve in Sub-Saharan Africa, and its evolution is mediated by economic, social and cultural conditions and practices at the governmental, institutional, scientific and interactive levels. (Farmer 2003; Iliffe 2006; Livingston 2012; Wendland 2010). Many Africans continue to combine multiple healing modes (Langlois-Klassen 2007; Langwick 2008; Dilger 2012; Moses 1994), and the World Health Organisation (WHO) estimates that up to 80% of Africans still seek traditional healing as the primary form of healthcare (WHO 2008; Green 1999). Many traditional healers have been forced to adjust to the social and politico-economic dynamics brought on by colonialism, post-colonialism and globalization (UNAIDS 2002; Swantz 1990). The disparity between the number of western-trained physicians and traditional medical practitioners remains high, and given this—plus the much lower cost of traditional medicines—many patients continue to seek healing from traditional healers. Current research demonstrates collaboration between both traditional and biomedical practitioners (Langwick 2008; Sugishita 2009). Nevertheless, while globalization can often be viewed as a selective process in terms of connections and collaborations (Ferguson 2006), some studies suggest that efforts to integrate traditional medicine with biomedicine have not been entirely successful (Hillenbrand 2006; Hill 2003). In this paper, we seek to build on this previous scholarship in our attempt to explore the dynamics of collaboration between *waganga* (Kiswahili: traditional healers/doctors) and other stakeholders in a larger, therapeutic ecology in Mombasa, Kenya, and as our findings suggest, collaboration is not only present, but occurs in many different ways (Langwick 2008).

For this paper, traditional medicine—also referred to as ethno-medicine—will be defined according to the World Health Organization (WHO) definition as the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses (Bodeker 2007). We suggest that while the differences between ethno-medicine and biomedicine between here are not entirely rigid or polar opposites, we approach biomedicine as an epistemology, practice and methodology to understand, interpret and treat diseases and health conditions based on systematic and rigorous “scientific approaches” such as the use of experiments, randomized control trials and quantitative approaches (Biehl and Petryna 2013). In contrast, we approach traditional medicine as an epistemology, practice, and methodology to understand, interpret and treat diseases based—not entirely—on apprenticeship, experience, and generational knowledge (Fratkin 1996). In addition, we approach traditional medicine as an epistemology that strives to link empirical phenomena about diseases and health to the meta-physical explanations (Fadiman 1997; Good 1994; Fratkin 1996).

As will be discussed later, a flattened definition of ethno-medicine fails to fully represent the complex realities and constant (re)negotiations that occur among and between *mganga* and other actors in healthcare systems delivery. Furthermore, this paper will argue that patients have variegated understandings of *mganga* and traditional medicine. Where biological understandings of disease and illness tend to be hegemonic, we attempt to build upon previous scholarship that approaches terms such as ‘biomedicine’ and ‘traditional’ critically, and to investigate how these terms are situated in larger discourses of (alternative) modernities and neoliberalism (Good 1994; Geschiere 1997; Biehl and Petryna 2013; Langwick 2010).

In Kiswahili, the word *mganga* (and its root –*ganga*) roughly translates to traditional healer. However, depending on who is asked, the word both denotes and connotes a plethora of ideas, images, or professions.

Table 1: Translations of *Mganga* and *Uganga* in English-Kiswahili

Dictionary	<i>Mganga</i>	<i>uganga</i>
The Kamusi Project	Doctor; physician; traditional healer; witchdoctor; shrub (used as fish poison)	Remedy; medicine (profession of); medicament; magic potion; healing
Kamusi ya Kiswahili-Kiingereza	Medical person; doctor; herbalist;	Medical treatment; traditional healing practice
Swahili English Pocket Dictionary	Doctor; medicine man	Practice of traditional and modern medicine
Google Translate	Healer; doctor	Medicine; enchantments; doctoring; magic; curing

Other dictionaries, including those written and published in East Africa, have similar definitions of *mganga* and *uganga* (Awde 2000; Mwita 2003; Ndalul 2000; see also Perrott 1965). When exploring its usage in contemporary Mombasa, the classification of *mganga* as a medical person or witchdoctor can have immense economical, social, ideological, and moral implications. In a time when traditional medicine is often viewed as “meaningless pseudo-psychological mumbo-jumbo” (Freeman 1992), it is critical to understand the multi-faceted definitions of *mganga*, and how these definitions—both historically and contemporarily—offer insights into larger social and political processes in the ecology of health and the place of *mganga* therein (Vaughan 1991; Beck 1979).

Historically, colonial governments looked down upon autochthonous systems of healing, and in turn, sought to inhibit local forms of religion and healing. In 1968, a Tanzanian newspaper, *Sunday Nation*, cited the witchdoctor as “the greatest evil in Africa” (Beck 1979). Similarly and created in 1925, the Witchcraft Act of Kenya was one of the earlier laws that sought to limit religious discourse and practices, within which traditional medicine often falls. Religion and healing practices are indeterminate concepts, especially pertaining to their practice and understanding in African contexts (Marshall 2009; Comaroff 1985).

[W]aganga conduct the majority of rituals that diagnose or resolve problems caused by a variety of supernatural agents...to help maintain the health of individuals, homestead and lineage members, and communities. [...] The current Witchcraft act (Cap. 67) contains ten sections which prohibit chiefs from allowing the practice of witchcraft and prohibit individuals from pretending to exercise witchcraft; supplying advice of articles for witchcraft with intent to injure; using witchcraft medicine with intent to injure; possessing charms; accusing persons of witchcraft; and attempting to discern crime with witchcraft (Levack 2001:384-385).

Seen as religious, spiritual, family, and community leaders, the spatiality—or the place in the social order—of *waganga* becomes challenged in this historical setting. In this paper, we attempt to build upon current and recent scholarship on health practices (Langwick 2008; West 2007; Swantz 1990; see also Bledsoe 2002) and argue that traditional healers, such as *waganga*, continue to navigate a contentious space where these colonial and post-colonial understandings greatly inhibit the healers’ modes of operation.

Along these same lines, it is important to explore the nomenclature and categorization of healers into static spaces—or flattened categories. The terms “traditional healing” and “biomedicine” fail to capture the phenomenological realities of tradition and culture, and how these two phenomena are constantly changing, leading to alternative and existing modernities (Geschiere 1997; Piot 1999; Appadurai 1996). In other words, the demarcation of medical practices among these terms falls short of acknowledging or appreciating the overlap of contemporary practices in a therapeutic bionetwork and the tradition that is constantly negotiating and renegotiating its spatiality overtime. These different healing practices are interpreted from constantly changing, but varied lenses among western, herbal, and spiritual medical practitioners from myriad backgrounds.

Moreover, many Africans, including Kenyans continue to seek and combine a variety of healing methods (e.g. herbal, spiritual, western biomedical) in order to find the best treatment for a specific ailment, as well as to promote holistic well-being (mind, body, and spirit). It is imperative to recognize the emphasis that traditional healers place on the body’s interconnectedness with the mind and spirit. Without realizing this, it is impossible to appreciate and understand the approach of many traditional healers (Beck 1979) or the notion that the ‘body is multiple’ (Langwick 2008). In this paper, we attempt to expand upon recent scholarship to suggest that there is likely a link between the representations of traditional healers—as created by government, state and non-state actors, religious institutions, media, physician networks, and other entities—and the efficacy of *mganga* in assuming this role as a holistic healer, specifically as these issues relate to the locale of Mombasa. Equally, the implications of these representations play a key role in the decision-making process of patients and offer unique contributions to our sociological and anthropological understanding of how the state frames, defines and operationalizes *mganga*.

Materials and Methods

A purposeful sample of 43 individuals—comprised of a physician, herbal healers, healthcare educators, spiritual healers, religious leaders, patients and other personnel—were recruited using affiliations with the Swahili Resource Center, Family Health Options Kenya (FHOK), and the Council of Imams and Preachers of Kenya (CIPK). Overlap of subjects existed within these groups, however; for example, many herbal healers also employed some form of spiritual healing, usually Islamically based medicine, in their healing regimens. There is also a reality that almost every human being is a patient at some point in their life, and this was interpreted as such in the analysis. A minimum variation sample with regard to participant location and place of residence was

sought to limit the influence of factors specific to locales outside of Mombasa. Ethical approval was obtained through Yale University's Human Subjects Committee located in New Haven, Connecticut, USA.

Professionals and patients were asked to participate in semi-structured interviews based on previously constructed questionnaires. Questionnaires varied depending on interview subject status as healthcare provider, religious leader or patient. The majority of interviews were conducted in Kiswahili at either professionals'/patients' offices or homes. Interviews lasted anywhere between 20 and 120 minutes, depending on participant availability and willingness to continue. Additionally, the interviewers allowed research participants to "lead" the discussion when it was reasonable to do so. Almost all sessions were audio and video-recorded when possible and after consent, and field notes were taken to enhance and supplement future data acquisition and analysis. Initial analysis began during interview process and some findings were applied and implemented in the then-future questionnaires in an effort to improve research quality and integrity. All names have been changed to respect participant anonymity and confidentiality.

Discussion

Varied perceptions and opinions of *mganga* suggest a strong relationship between the representations of *mganga* and collaborations between *mganga* and other actors (e.g. religious institutions, doctors, hospitals, government and other non-state actors). Additionally, such representations affect the healthcare decision making process of patients, especially with regard to combination of healing modes.

Typologies of Mganga

The definition of an *mganga* was a central question of the research—who is *mganga*? Insights into its meaning ranged from positive to negative. In our research, we found a variety of opinions and associations as will be discussed below.

Perceptions of Positivity

It is worth noting the way that *mganga* define their own practices. Bakari, who is a well-known Digo healer in Likoni district, first defined *mganga* by presenting two sub-groups: i) those who practice healing and prophylactic care by using trees, plants, roots and herbs and ii) those who use trees, plants, roots and herbs in addition to the use and invocation of spirits and prayer in order to promote general health and well-being. No distinction was made as to any particular faith tradition with regard to "spirits and prayer," although Bakari himself is a practicing Muslim. He noted that he utilizes the Qu'ran in his healing practice, as opposed to other spirits and self-categorizes as a member of the second group. Scholars have documented a wide array of classifications that challenges the distinction between spiritual and herbal medicine. The classification of traditional medicine we have presented in this paper was in the spirit of preserving the categories our respondents have used themselves in our conversations and does not reflect the complexity and existence of different form of tradition medicine. For additional discussion on typologies within the context of traditional healing, please see Fratkin (1994) and Ngwenya (2012).

Bakari discussed at length the social and historical significance that *mganga* have played both in pre-colonial and post-colonial times. Medicine along coastal Kenya was prevalent prior to colonial and imperial expansion. Bakari notes, "[i]t was my brother that called me into the practice of healing. He said that I was ready to learn the art, and it was he who taught me the intricate medicines, herbs and practices that I now incorporate into my life [...] we haven't read science books; rather we study through actions." This pedagogical phenomenon lies at the center of understanding the nature and practice of *mganga*. The transmittance of knowledge through generations and health practitioners has manifested itself for dozens of generations (Sivaramakrishnan 2006; Rasmussen 2006). At the same time, though, another healer, Mohamed, discussed at length the many books on Botany and Islamic medical regiments that he has read and incorporates into his daily practices, demonstrating the dynamism by which methods of "apprenticeship" are experienced. It is not a stretch, then, to consider the acquisition of medical knowledge as theoretically similar to western medical systems and institutions: coursework and apprenticeship—that is, learning by doing. Dr. John Abasi, the head physician at a local clinic that will be referred to as Clinic Z, states that:

"A traditional healer for me is a person who is giving medicine that is not based on modern science, but it's something that is handed most usually from a parent to someone else, someone who has done apprenticeship [with] a medicine man so that you are able to identify the plants. Most of the traditional healing is usually plant medicine, usually herbal medicine, so [it's] something which you have to learn."

His definition closely aligns with the first group that Bakari describes—those who practice the art of healing and prophylactic care by using trees, plants, roots, and herbs. Similarly, this definition corresponds to that of various dictionaries in Table 1, especially *Kamusi ya Kiswahili-Kiingereza* and its interpretation of *mganga* as an "herbalist." Abasi also offered a useful anecdote in understanding traditional medicine in a hospital setting. Similar to Langwick's (2008) discussion of traditional medicine in hospitals, Abasi discussed a case whereby a man was in a coma for several days. Upon administering care, the man did not wake. It was only after a traditional healer came one day that the man woke up. He claims, "While I don't understand it," I respect its usage. Not all actors, though, have such positive associations and perceptions of *mganga*.

'They Call Us Killers': Negative Perceptions of Mganga

Historically, ethno-medical healing practices have been dismissed by populations at large, especially among African medical professionals, or relegated to an educational outreach role as opposed to a healing one (Green 1999; Dilger 2012). In our research, two spiritual healers we interviewed both adherents to Christianity and members of charismatic churches, distrusted *mganga* and the practice as a whole. Pastor Charisse states, "*waganga* are sorcerers and witch practitioners. Most of them are phonies and just try to collect money. They put up signs but are not real. They advertise for things like love, work, jobs, and other social relationships." Winda, another healer from Mombasa town, agrees that they are "fake." She went on to say she has no faith or

belief in traditional or western medicine. “The only hope is spiritual.” To some extent, Pastor Charisse and Winda’s opinions about *mganga* as quacks and phonies resemble a widely documented perception of ethno-medical practitioners in colonial and post-colonial settings. More specifically, these comments highlight the persistent ideological contentions that are only exacerbated by lack of more formal recognition in a larger therapeutic ecology. Comaroff (1985) also suggests that charismatic leaders and the church are within a change continuum, whereby indigenous African practices like healing are incorporated into religious practices.

These connotations of sorcery and witchcraft stem from documented beliefs—that is, many *mganga* indeed utilize some sort of spiritual means in the giving of care—whether it is Christian, Islamic, or indigenous beliefs, as was explained by Bakari himself. While Bakari, a practicing *mganga* did not delineate or offer a sub-group of *mganga* that just use spiritual methods, it is indeed well-noted that many *mganga* employ charms and other spiritual methods (Geschiere 1997; see also Fadiman 1997). Sometimes, the utilization of “spirits” is done so with exclusion of herbal medicines.

To the other point, we observed that the perceptions of *mganga* as being “phony” is widely held, especially given the modern trend in advertising for what the pastor dubbed as nonsense. Throughout Kenya, small billboards in red and blue writing are nailed onto trees, road sides, and building fronts. Dr. Abasi stated that all of these signs should be removed completely due to their unreasonableness. This concept and its reliability, though, deserve further research and inquiry.

Not all *mganga* advertise or promote their services in the form of ‘healing’ for love, social relationships, and love. The mere fact that some *mganga* utilize this method problematizes the space that *mganga* inhabit. Although we did not organize interviews using these billboards, it offers a unique perspective on ways in which tradition and culture are being invoked in response to global market forces—an alternative modernity (Appadurai 1996; Ferguson 2006). While it remains debated whether or not *mganga* can provide potions to ‘find love’ or ‘secure a job,’ these billboards can be read as social texts describing how ‘traditional healers’ are finding ways to be accepted in mainstream Kenya, as well as providing solutions to well-known urban problems, such as seeking employment, finding a life partner and becoming successful.

In a similar vein, it is illuminating to discuss negative perceptions of *mganga* from the perspective of *mganga*. By exploring this mentality, one is able to further understand issues of representation. Dalila, a Mombasa healer, speaks clearly to this issue:

Those people in the hospitals, in many instances, they don’t like us. And we are helping them but they don’t like us. ... My view is that massage[ing] has been practiced for ages before even the hospital were established here. People gave each other massage...so when someone gets pregnant [she] is able to deliver. If the baby is positioned, he [is] properly oriented and the woman delivers the baby the right way. But the doctors disagree...they help us but they don’t really like us. They say that we are killers. In hospital people also die but they tell us we are the killers. So they don’t like and therefore, we don’t have any collaboration with them. So the only collaboration we have is through these clients that value us. But those people don’t like people like us...They call us killers.

Here, Dalila is discussing a technique that involves the massaging of the woman’s belly in order to reorient the fetus “in the right direction.” She discussed at length how this process works, and then explains, as seen above, how western-trained physicians disagree with this practice. When babies die in the hospital, it is a tragedy; when babies die in her office and home, she becomes a murderer. Dalila’s testimony about doctors’ attitudes towards traditional birth attendants illuminates an ongoing antagonism between traditional and biomedical professionals; yet, at the same time, it also demonstrates how biomedicine and traditional healing come together through the patient, sometimes due to the knowledge of the doctor and sometimes not.

Combination of Distinctive Healing Modes

In many sub-Saharan African countries, the body is not viewed as separate from the mind and the spirit. Given this ideology, illness, disease, and well-being remain intertwined, and the context of one dimension must be seen in light of the other in and among the physical, emotional, and spiritual domains. Multiple stories will be illuminated here in order to illustrate the ways in which *waganga* partake in a multi-dimensional form of healing. One such story is of the previous healer, Dalila, who “give[s] medicine with Allah’s faith.” She states:

Even the police officers come to me for massages, government people in fact. One of them had a baby recently. One of them came to me with a stomach problem. I asked if she had gone to the hospital. What did the doctor say? She said, ‘I was told that I still have a lot of time before delivery.’ So, she invited me to her house, and her husband was there. I told her she needs to do *tizi* [interpretation: massage]. It was just [my thoughts] from my mind. Because the baby is already large, it needs to be bothered, so it can come out. Therefore, she started *tizi*. She continued to do *tizi tizi* and by morning she delivered. She called me to tell me that *tizi* helped her, and I told her to take some medicine. She said ‘[W]e police do not take medications.’ I responded by saying it was ok. She realized that what I told her was the truth.

Here, the story reveals that not only did this police officer first go to a hospital, but also that this hospital said she would not deliver soon. One may infer that the officer’s action to seek further treatment or advice from the *mganga* indicates that she felt at risk in some ways, health-wise. Although brief, this interplay between biomedicine and local healers confirms the claim that patients combine various healing modes in order to acquire general well-being. However, this narrative begs further discussion as we observe convergence as opposed to antagonisms. Medical anthropologists have documented that patients’ preferences about a particular system (i.e. biomedicine or traditional)—even as these systems are not completely separate—does not determine their health seeking behavior. In other words, clients may say that they prefer hospitals or *waganga*, but they may utilize multiple healing modalities. Patients also make decisions based on issues of access and quality of care, cultural appropriateness and respectability, affordability and one’s position on disease trajectory (Nyamongo 2002; Fratkan 1996; Farmer 2003; Hamdy 2012).

From a practitioner’s standpoint, the previous narrative presents an interesting case that complicates our understanding of scientific or contemporary versus traditional. Trained as a nurse in a hospital setting, Dalila eventually realized she could have her

own business doing the same exact practice: delivering babies. Here, she responds to social and economic circumstances by combining an alternative modernity in response to a market force and an inexorable phenomenon—human reproduction. What we mean by this *alternative modernity* is the notion that *mganga* is not a remnant of the past, but rather an active force and profession that encompasses knowledge, tradition and culture in responding to current market forces. Dalila utilizes her biomedical knowledge about human reproduction and translates it into social and cultural contexts of her surrounding. Despite her knowledge from working in modern hospitals, though, she is referred to as a traditional birth attendant—and a killer. All her materials consist of modern equipment, such as gloves, disinfectants, razors and clean beds; nevertheless, she supplements her practice with traditional medicines. Modernity or alternative modernity does not come directly to Africa from Europe. As Brian Larkin has shown in *Signal and Noise* (2008), it is through Indian films that Hausa Nigerians forge and negotiate their own modernity. He has coined the term “immediate modernity” to show that there are intermediate factors that shape modern influences in contexts like Africa. Therefore in thinking about modernity and alternative modernity, one has to also highlight these other intervening sites. Lastly, the colonial process was never equal. What was practiced in the colony and what was practiced in the “metropole” was different—problematising the idea that there is a linear flow of modern ideas or a vertical topography of power (Ferguson 2006).

While Dalila’s account of the police officer informs us of the reality of modal combination, it fails to illuminate exactly the thought processes of the officer in question. The story of Fila, another respondent, and her battle with tuberculosis and subsequent efforts to cure the illness, offers keen insights into this question.

It’s a tricky story. I used to live in Nairobi, and I thought I had asthma, but it was a bit [suppressed]. So, when I was in Nairobi, you know Nairobi is a cold place. I started coughing, and I couldn’t sleep at night. I couldn’t breathe. It was becoming a problem. So, I used to take antibiotics and serums, but the problems would occur again. I coughed for a very long time. I moved from Nairobi, came to Mombasa, went back home where my parents both are in the Western Province, and then I came back to Mombasa. I was still coughing. I coughed for more than one year. Yes, it was a real problem. So, I only got medicine after an aunt of mine, who is a nurse at Loitoktok. She called me and I could not speak properly. I had a sore throat, my voice was down. So, she called me there to get treated. When I went, they did tests (HIV, tuberculosis, asthma). That is when it was discovered that I had asthma and TB. So I was given a two-week treatment to see whether it was the asthma or TB disturbing me more. So I went back to Nairobi, tried the trial medicine, and I got better. So, when I went back to the hospital, I was given 2 months of drugs to continue. I should come back to the hospital after two months. So I went and took my drugs properly, then just when the medicines...were about to finish the duration, there was a bit of a problem. Loitoktok is very far from Mombasa. [One] needs a lot of money to travel there, but I was told that if one has TB, treatment is the same all over the country. So, if you just show your card...you’re given small card, whereby everyday you take the tablets, [and] they put a tick on that card. So I tried visiting hospitals but I could not be given the drugs. It was a real problem, and I was disturbed. I was afraid I would start coughing again.

Fila’s battle with asthma and TB (potentially) partially stems from delay in seeking treatment, as she “only got medicine after an aunt of [hers]” called her to be treated. Disease, illness, or malady is—in one interpretation—a matter of self. Vs. others—where others are bacteria, viruses or foreign pathogens (Stoller 2004; Latour 2005) The liminal state of fear between overt risk factors (i.e. genetic, exposure to pathogens, socioeconomic conditions) and diagnosis—or prognosis—may influence one’s decision (not) to seek healthcare. Nevertheless, Fila’s journey is fraught with issues of access—and a potential consequence if she fails to adhere.

So I started looking for ways to get the transport to get to Loitoktok. It’s a big problem. I looked for hospitals to give me the TB drugs, another hindrance...I started praying for myself first, I was telling God, you know, where I’ve been I don’t want to go back, I was coughing all of the time. I cannot sleep. I cannot walk fast. Climbing stairs was a big problem. I’m always panting. I cannot sleep at night. So I told God, ‘Now I have no one. You just save me. If the bacterias of tuberculosis are 100, then keep them 100. Don’t multiply them. Don’t reduce them.’ Because you know the treatment is a bit tricky. If you miss one tablet, another day then they multiply. So I did not cough, but my asthma will come when it was cold, then it would go. But, I didn’t cough like I used to. Then, I met Pastor Alice. We started praying about it. Then one day she told me that God has said everything will be OK. So, me I believe I’m fine because if you see someone who has tuberculosis, then I do not look like one. So, me now, I was healed of TB. I’m waiting to get an x-ray at the end of this month, so that maybe those who are not sure about the miracle I got, they will look at the x-ray I did when I had TB, and my lungs were weak, and they had burned out, and the one that I’m going to do at this end [of the] month. Now I only have asthma and I’m sure it will go with faith.

Fila’s account sheds light on the combination of spiritual healing and biomedical healing. Our findings confirm that many people seek and participate in alternative treatments for tuberculosis (Steen 1999), such as prayer, to combat physical ailments or forces. However, what remains more unique about Fila’s case is the timing and order in which these healing modes were sought. Fila’s first choice was to take antibiotics and serums. It is unclear whether she received these from a clinic or from another source. Nevertheless, after these methods failed, her aunt’s invitation intrigued her and she went to get tested, a service that seems to be readily available at many clinics, and not a possibility in the office of *mganga*. Although the medicines were helping, she was unable to afford transportation to receive more; this is when she turned to prayer. Her decision, then, can be seen in terms of accessibility.

Similarly and after deciding to seek healing from God, she did not seek other options in addition to this spiritual method. Instead, she decided that ‘if God is healing me, then after four months, I will get an x-ray.’ Here, Fila is emphasizing the importance of spiritual healing for physical ailments (e.g. attending sermons, collective prayers, specific prayers and fasting); yet, simultaneously, she will “get an x-ray” to see whether or not the healing occurred, even if she doesn’t “look like one [with TB].” This approach towards healing is not uncommon; that is, utilizing the diagnostic potential of western biomedicine in order to verify the efficacy of other healing modes. More interesting, though, is juxtaposing Fila’s approach to seeking healthcare with that of her grandmother.

Stationed in Kisauni district of Mombasa, Fila’s grandmother, also known as Karimu, uses traditional medicine. But at the same time, she doesn’t discount the power or utilization of western methods or spiritual healing. Currently, she is fighting diabetes and hypertension. She recounted the following story, which illuminates key issues and factors that mediate the decision-making process and overall treatment that she experienced:

In 2004, one night I slept but couldn’t sleep. I woke up, I don’t whether it was malaria or what, I couldn’t know what was wrong with me. So I decided to go to Coast General [Hospital] here. When I went, I went and saw a doctor. He tested me for malaria, and I didn’t have malaria. I thought I had malaria initially. You know, we ourselves, you can say that we have malaria, and you can just take over-the-counter medication. So, I said I had malaria, but he said let me check. I couldn’t

sleep, I was feeling pain everywhere...then I went to the hospital, he tested me and said I don't have malaria. They asked me 'in your family, do you have anybody with diabetes or pressure?' I said yes. They tested me at that particular time, and the sugar was not high. The pressure was so high, he said...They put me there, and told me to sleep. I said I am not sick with this.

In conversation with Karimu, we observed themes of self-diagnosis, self-medication, and denial of a condition (i.e. hypertension) emerging (Nyamongo 2002). She continued her narration, and became more suspicious of the hospital:

They said your [Karimu niece's] grandmother has a very high high high pressure, and she could have a stroke at any time now. To the niece: "What are we to do? We are afraid to tell her. "Let's screen her. They pierced me three times with needles. You know I was at the emergency wing. There, they brought one sick person who was very sick, and I was not feeling sick, it was just at night that I was not feeling sick. It was restless. I told my niece this person is going to make me die. She, herself, is sick and she was dying actually, and we were in the same place....They told me I should just sleep....After two hours they said we will go and take the [blood] pressure. He gave me medication. For 12 hours they discharged me and told me my pressure was bad. They told me I should come back to hospital after 3 days to check it again. From that time...I go to the hospital every month, once, to be tested.

Karimu's first choice was to seek western medical care at a major hospital in Mombasa, Kenya, Coast General Hospital. Coast General Hospital is one of the top hospitals in Kenya and serves a large population of people from both Mombasa (and its constituent districts of Kisauni, Likoni, Mombasa Island, and Changanwe), as well as people from the Greater Mombasa Area.

As noted, Karimu also expresses or partakes in self-diagnoses. She repeated on multiple occasions that she was not indeed sick, both respective and irrespective of being in the emergency wing around a sick person that "is going to make [her] die." Her conceptualization of her illness speaks to a larger phenomenon that is noted among humans from all cultures: self-diagnosis. Many people, especially in sub-Saharan Africa, both diagnose and treat themselves in some fashion for diseases, such as malaria (Ruebush 1995; McCombie 2002; Green 1999). Karimu's actions can be observed through an ethnographic lens of self-diagnosis, and how such an action, can mediate the decision of a patient to seek—or not seek—treatment of a specific malady (Nyamongo 2002).

It is important next, then, to highlight Karimu's combination of healing regimens. In the conversation with her, she began recounting her journey from western biomedicine to traditional medicines—a journey that was fraught with issues of trust and suspicion—to combat her diabetes and hypertension:

I was visiting in Nairobi. I went to visit my sister. Then I bumped into my sister's neighbor and they had a doctor that had good traditional medicine. Then, I went to see him. He said he had medicines for arthritis, diabetes, [high] pressure, medicines for everything, and he said you can be healed completely of everything, but I will need KSH 15,000, but I for now, if you give me KSH 200, I will start you off, and I saw people taking. I said why not? I am not losing anything. Why don't I try? He gave me his [medicinal] bottles. Then, when I went to get tested, the sugar had gone down to 5.6, and I had [before been] running into 13.7. I said that this medicine is very good, and that I will continue to use it. Then I started using it. And now, when I go, sometimes it is as low as 4 [or] 4.8. Then sometimes I stop using it for a week, and if I go, I see that I control myself now...I use this medicine on a weekly basis.

Karimu later explained that even while she takes these medicines daily with her tea, she does not forfeit the opportunity to get tested at the hospital. Here, we again suggest that a patient relies on western modes of healing to confirm the efficacy of traditional medications, in combination with the belief of the body as a site of knowledge and unknowns—that is, while she may feel healthy, she still recognizes a need for additional indicators of good health, i.e. laboratory tests. The utilization of diagnostic tools in order to test the ability of herbal medications seems to be an area of growing interest, both institutionally and socially (through a patient's decision such as Karimu's). Lastly, and speaking to a larger issue of interaction, Karimu also offers her thoughts on the concurrent use of two healing types (western and traditional):

"I don't think they [western doctors] would approve you to use both [western and traditional medicine]. They will discourage you and tell you this traditional medicine has its 'effects.' And I don't think a patient will be open enough to tell the doctor [he or she is taking] traditional medicines in conjunction with the western medicines. I don't believe so."

The fear of patients to discuss the concurrent use of herbal medicines with their physicians in western hospitals speaks and alludes to the larger ideological tensions and lack of collaboration or mutual respect between these two modes of healing, especially when it becomes an issue of (non)compliance (Fadiman 1997). After discussing the ways in which patient's healthcare seeking behavior is influenced through personal and biological knowledge, it is important to now turn to our findings to questions of collaboration. These associations and partnerships—or lack thereof—exist and do not exist as a result of both official (i.e. governmental policies, programs, etc.) and unofficial channels (e.g. patient decision).

Collaborations, Associations, and Coordination

Today, the collaborations between healer networks and state and non-state actors play a crucial role in Kenya's healthcare sector. The continued lack of adequate healthcare institutions and programs has created a pressing situation for a large portion of the population. Here, the current status of relationships between some traditional healers, governmental and non-governmental institutions will be explored in three parts: state and non-state actors, physicians, and religious institutions.

The role of the local, provincial, and national government on healthcare issues remains monumental. Hence, in a society where a large proportion of the population still relies on traditional medicines, it is critical to highlight the ramifications of the government's (in) action or approach to support the traditional medicine sector.

First, at the time of this research, the government of Kenya has yet to recognize traditional healers under the Ministry of Health, and therefore offers minimal, if any, legal protection under this ministry. Rather, they remain under the Department of Culture and Social Services. In other words, while they traditional healers view themselves as stakeholders in health and medical area, they are relegated in the cultural and social services domain. This has been stated in previous literature (Ayoti 2008) and our multiple interview participants also confirmed it. This governmental entity (Culture and Social Services) is responsible for registering and supporting the industry and its practice.

Another entity, the National Traditional Health Practitioners of Kenya (NATHEPA), involves itself in the certification process. Dalila, formerly a registered nurse, affirms that the certification is important.

"It is important to be recognized. There is a ministry where I can be registered. You know I thank God, if I bring a mother here, I can help her. These certificates, you know, if a mother comes in, I have my skills and these certificates help me [to help her].

In this case, the healer understands the certification as a way of being recognized by the government as a healthcare practitioner. Without certification, problems—for example an unqualified healer attempting to provide adequate treatment—could occur. In turn, a healer could be arrested or put out of business. Certification helps prevent that. The presence of the certificate, in this context, serves a symbolic function; that is, because of the close association of certificates and the government, a healer cannot be harassed. For Dalila, it seems that certification is more a means of protecting herself from police and government harassments as opposed to concrete ways the government and TH association can collaborate to improve access, quality of care and coverage. The current nature of collaboration seems to be about control and surveillance more than building a system of care. NATHEPA also arranges for herbal medicines to be sent to the Kenya Medical Research Institute (KEMRI) to be tested for toxicity and carcinogenic properties. Not all drugs are required to be sent; only a few are required to be tested. If the medicines that are sent pass the tests, then certification follows. Bakari, however, still feels as if the support is limited to such actions, actions that, if objectively observed, seem to only make sure that these *waganga* are not endangering the lives of their patients. In other words, governmental support only exists nominally. Out of frustration he states:

Perhaps the government thinks that these traditional healers will be recognized because they have registered through the government. They are supposed to register in order to be recognized. But, when we register with the government, it stops there. There is no follow-up, no meetings, no gathering among western physicians and us. There are no special gatherings or meetings to bring us together. There is nothing that provides us with a way forward. [...] The coordination does not exist.

The lack of fruitful support or initiatives from the government greatly inhibits the ability for *waganga* to improve their practice or collaborate with stakeholders in the public health sector. Multiple research participants acknowledged the growing importance or potential of herbal medicines if more support was given. For example, several participants (including two healers, one physician, and two members of a general discussion group) hinted at the advantages of healers grinding and encapsulating their medicines for better access, efficacy and coverage. These actions would not only possibly improve the quality and quantity of herbal medicines, but they would also lower the cost of treatment for patients. However, no research participants spoke of any programs supporting these actions.

In a broader example of collaboration—the case of epidemics—we suggest that *waganga* are relegated to a minimal role in healthcare delivery (Dilger 2012). During a recent cholera outbreak, Bakari cites the collaboration between the Kenyan government and networks of traditional healers that seems to relegate them to pre-determined categories. In this short period of time, the government realized they needed to employ the network of *waganga* in order to most effectively serve the communities at risk. However, rather than supporting the *waganga* in administering treatment (e.g. funds, setting up clinics, advertising), Bakari recalls how the government placed *waganga* in a role of community education and sensitization. Instead of allowing them to use the drugs they possessed to combat the outbreak, they were instead given the task of promoting awareness. Government's placement of the *waganga* simply as educators has a long history in the colonial Africa. Ann Beck (1979) writes on how the British regime in Tanzania used *waganga* to teach about common diseases. Similar to the relationship between the colonial state and *waganga*, present-day contacts usually relegate healers as community mobilizers and educators. In other words, their knowledge and views of disease are not part of the terms and considerations the government takes in addressing public health challenges—a reality only reinforced by NATHEPA placement in the Department of Culture and Social Services, rather than the Ministry of Health.

Non-Governmental Organizations

Throughout eastern and southern Africa, some coordination and associations exist between non-governmental organizations (NGOs) and traditional healers, especially with regard to educational and counseling programs (Courtright 2000; Richter 2003). Research indicates that community health centers have attempted to establish symbiotic relationships with networks of healers, especially during shortages of medicines or when initial regimens of treatment fail (UNAIDS 2002). Our research confirmed these studies.

Multiple interviews were conducted with healthcare educators who worked for Family Health Options Kenya (FHOK), a national organization aimed at providing voluntary counseling and testing (VCT), as well as other forms of educational support and healthcare. All of the respondents indicated that they neither support nor deter patients from seeking the skills and healing methods of *waganga*. The stance of each FHOK staff was neutral; however all observed that many of their clients combined various healing modes. One health educator, Fila—the same Fila who was battling asthma and TB—focuses on sexual education. She states:

You know there are different people in one society. There are people who will opt to go to traditional medicine, because I've heard of herbal contraceptive, but I've never seen it or tried it. Then there are some people who are conservative, like the Catholics. They never use contraceptive, they go with the safe base. You know that, right? So it's a bit tricky. You

know, some will fall sick, they'll go to *waganga* and witchdoctors. Some will get sick, after going to many places without being treated properly, then they'll come here in the clinic. [...] Even some go to *waganga* and also come for prayers.

Integration of various healing modes is commonplace throughout Mombasa Island and the adjacent divisions. Because FHOK clinic specializes in VCT, research participants recalled a number of accounts whereby clients would first have sought *waganga* to be healed, especially in the case of HIV/AIDS. Jabari, who is one of the head counselors at FHOK, Mombasa Island, shared the following story:

You know, something like HIV, when it started here in Kenya, people thought that it was something like a curse, or maybe you have eaten something bad, or someone has thrown [a curse] it to you. At first, even up to now, some people don't believe that they have the virus. They believe maybe they have been bewitched. They don't believe in many starting on treatment or therapy that these hospitals have. So it's still there. So, they go to *waganga* to seek treatment. [...] Sometime back, I was doing this, they call themselves CHW (community health workers). We were going to homes where people were HIV positive, to try and train their caregivers on how to handle them. So, we are meeting things like this. They don't believe that we could help, but when we start on them some drugs, when you're sick you can allow anything to come. But they mostly believed in *waganga*. That's why they were staying at home instead of in the hospital. But when we started giving them our drugs, like immune boosters, they started seeing some improvement. So some of them changed, but some of them still *remain* to be treated by *waganga*.

The question of how to further encourage collaboration among various stakeholders remains an issue and topic of further research, especially given unique cultural and social conditions in a given society or community. Jabari's recollections of his work with AIDS patients and their reliance on traditional medicine does not show a linear movement or adoption of biomedical therapies over HIV/AIDS, but demonstrates that even as patients use immune boosters, they continue to utilize different modes of healing (Good 1994).

Physician-Networks

Relations between western "biomedical" practitioners and *waganga* remain one of the most contentious and antagonistic. The colonial construction of "traditional," as relating to the practice of indigenous medicines produced a dichotomy in nomenclature that is still employed today. The Witchcraft Act of 1925 shamed local medical doctors to hide and conceal their practices. Interviews conducted confirmed a similar reality, as some healers indicated that they preferred to avoid governmental registration, for fear that the government would abolish their practice.

Much research has been performed on the efficacy of herbal medications and treatments against, for example, malaria (Khalid 1986; Gbeassor 1989; Gakunju 1995; see also Zirihi 2005). Coupling this contemporary research with a historical secrecy—a form of protection in the absence of formal policy and legislation—among traditional healers and their medical mixtures creates an antagonistic space between physicians or researchers and *waganga*. Fila stated the following:

There is a discussion that yes the herbalists are not sometimes true at heart. Some are fake, but some are genuine. But then you find a genuine one. He's discovered a good medicine; then he collaborates with the lab and the doctors and the nurses and all. Then, he is called *mpigabafu* [term in Kiswahili that roughly translates to "phony."]

Waganga desires legitimacy within the therapeutic market, of which the government is a main player. Yet, the distrust of the state as a fair player—one that is responsible to the welfare of the state itself, as seen in elections and land access, is also mapped into the use and sale of traditional healing and medicines. And as the next paragraph describes, a healer's medicines would then be taken and transformed into an effective medicinal regiment.

They get a better medicine for the disease. Then, that guy from the village never gets even a penny. So, the herbalist has an idea but is scared to go and make noise and tell the doctors and researchers, because there isn't anything he will get. It is like when the South Africans discovered the vuvuzelas. They don't have even one shilling.

This ideological phenomenon of pharmacological testing (Matu 2003) and bio-piracy was often cited by study participants. Self-perception of *waganga* on the opinion of western, biomedical physicians provides keen insight into representational issues. Dalila is a practitioner focusing on women and reproductive health. She had formally worked as a registered nurse. She states, "Like I was saying before, it isn't a relationship where they don't recognize us. They do, but... [t]hey are the big people and we are the small."

The above-statement highlights a key issue of trust between *waganga* and western medical practitioners and researchers. With a lack of trust comes a lack of communication and collaboration. Contrarily, though, associations between western, biomedical institutions (e.g. hospitals and clinics) and *waganga* have been cited and noted in previous studies and reports (Ndhlalambi 2009; Courtright 2000). This integrative phenomenon was noted and confirmed by research participants:

I do have some such callings from Amani Medical Clinic, here [participant points towards location of clinic]. They have a patient inside. When they find out what is this man, they say, call Mosi here. 'Hello, umm you are required at Amani Hospital.' Sometimes I reach there and the man has already gone, so they are still having a drip of water on his body. 'Why are you putting water in a man that has already gone?' He has already passed. [...] [I am called to the hospital when] there are sick people sometimes who are paralyzed or [participant begins to imitate asthma attacks]. Now, when I arrive at the hospital, I say this person doesn't have sickness. This is the devil.

Other stories like Mosi's were also heard. It has been well documented that there is relationship between spiritual sicknesses and the physical manifestations of the body (see, for example Fadiman 1997). In such times, western "biomedical" practitioners call upon

local *waganga*. These findings have deep potential for improving associations and respect between various healing networks. Moreover, such collaborations could speak positivity into the current feelings of belligerence and bitterness felt by many *waganga*.

From the physician perspective, Dr. Abasi explained his relationship and views of *waganga*. He states, "I appreciate the significance of traditional medicine. It's very important. In fact, you'll find culturally, all types of people have their own traditional medicine, even in Europe. [...] Herbal medicine is becoming again prominent. It's being given now in form of tablets. Technology is actually beginning to appreciate it."

He spoke to the future potential of supporting *waganga* and the possibility and potential of such support could have. This same physician indicated that patients that remain in the in-patient ward of his clinic also bring in *waganga* to supplement the medicines he is providing. "These patients trust our medicines, but their relatives believe they have there is a space for traditional medicine. Sometimes we think a visitor has come to see the patient, only to go in there and find that someone is administering some form of traditional medicine. We don't discourage it, but we don't know what chemicals are being given. My fear is poisoning the patient."

These collaborative relationships shed light on patient and familial beliefs in holistic healing and speak to the larger phenomenon that collaboration—or combination in this sense—can be achieved at the patient level (Langwick 2008). Improving the relationships between healers to offer comprehensive orientations to treatment begs the larger issue of cultural appropriateness, patient bed-side manner, and respect for patient's and their families' views.

Religious

Relationships between missionary medical services and *waganga* have historically been fraught with hostility (Jennings 2008; Vaughan 1991). In the eyes of the colonialists and missionaries, *mganga* was a witchdoctor and a societal figure that represented dark and secretive practices. In one view, the triumph of western medicine over traditional *uganga* was a victory of light over darkness—or good over evil. It has been argued that contemporary traditional healing practices are a form of resistance to the aggressive evangelistic campaigns, which accompanied the creation of the public health institution in the early 20th century (Green 2003).

While a lot of changes have taken place regarding the view of *mganga* and his or her relationship to the "biomedical" domain, *mganga* indicated that they are perceived by religious institutions in a negative and skeptical lens. More specifically, what does collaboration entail or even look like between these two groups? Among the traditional healers interviewed in this study, several responded to this question by stating that religious leaders do not want to collaborate or approve the work, even though a number of sheikhs are also herbal and spiritual healers. Bakari, a Muslim healer, agrees with these sentiments. He states, "The sheikhs do not get involved in promoting or endorsing our work, because they see that we mix *shirk* with our healing." This statement has been correlated and confirmed with several of Bakari's cohort.

Abdul, an acquaintance and former sheikh, recalls how he engaged in acrimonious polemics against healers before he himself felt the call to become an *mganga*. He describes a story whereby he used to deliver sermons that attacked the practices of *waganga*, such as dancing, singing, spirit possession, etc. He argued that such actions were incompatible with Islamic doctrines. However, after he received a call to become *mganga* he changed his view, and stated that the practices were legitimate; at the end of the day, he was simply helping people, which is what he called, "an Islamic virtue."

Another negative association between *waganga* and religious institutions can be seen through an interview with Pastor Charisse. She expressed that "all healers are fake and deceivers." She pointed out that the idea of love potions is completely "absurd." Here, the legitimacy of *waganga* is called into question, given a larger association and categorization of *waganga*—regardless of whether these *waganga* practice herbal medicine, heal through spiritual means, or engage in "love potions." The automatic classification and labeling of *waganga* as "fake and deceivers" demonstrates an area of tension between religious institutions and networks of healers because they are not seen as legitimate or "holy."

However, claiming that the relationship between *mganga* and religious leaders is always marked by contestation is a misreading of the reality on the ground. *Waganga* have to navigate complex, social, political, and economic constraints in order to elevate themselves as legitimate healers, and many of them are religious in their own manner. Our findings simply suggest a tension. Among Muslim leaders that were interviewed, some *waganga* are also sheikhs, in their own local communities and mosques. However, these individuals that combine healing and religious roles distance themselves from other *waganga*, by presenting themselves as healers who utilize forms of healing predicated on religion and other Islamic texts, as opposed to other indigenous modes of healing.

For example, Sheikh Ibrahim currently resides and practices medicine in Old Town, Mombasa. He uses a number of Islamic medical canons. He incorporates figures like Al-Razi, Ibn Sina, and Al-Zahrawi. Sheikh Ibrahim identified himself with a particular Islamic form of healing known as *Unani*, which previous literature has explored (Ahmad 2008; Pandey 2008; see also Javed 2009). This is an Islamic medical system widely practiced in the Indo-Pakistani region, and given the significant migration of people from this region to east Africa, especially the Mombasa area; it is also not uncommon to find in coastal Kenya. It is tempting to assume that sheikhs are more open to *waganga* who use these texts, as opposed to those who receive their knowledge through oral transmittance of knowledge. Preliminary findings suggest otherwise. Finally, if healers combine both herbal medicines and spiritual healing, it is important to realize that in doing so they assume alternative identities and subjectivities, and their associations must be understood in those terms.

Conclusion

The goal of this study was to illuminate complex relationships and perceptions around *mganga*. As it exists in popular imagination, the term is loaded, complex, and a site of contestation. For some herbal healers, the term is technically accurate, but it has also grown to include those who are not strictly herbalists. These fluid definitions and categorizations contribute to aforementioned issues of representation and legitimacy.

This research does suggest openness in Mombasa to combining traditional medicine with other forms of healing including biomedicine, by health practitioners, and certainly by patients. However, problems of how different groups of healers are

represented have negatively affected these intergroup relations. In light of the research findings, the governmental system of organizing and licensing traditional healers might benefit from a reexamination in an effort to identify additional means to demystify *waganga*. Many worry that NATHEPA was simply a way for the government to gain information on who practices traditional medicine as a means of controlling them. Consequentially, *waganga* stay underground. Policymakers should examine the possibility of reforming the system in order to allay these suspicions. Policymakers might also consider new ways of connecting patients to their healthcare providers, especially in cases where patients choose more than one type of healer. The research demonstrates that many patients are already willing to seek and accept many different types of health care, and combine herbal, spiritual and western approaches. However, it is clear that there is limited collaboration, let alone communication, between these different networks of healers. Consistent with WHO recommendations, the Kenyan government should seek ways to encourage collaboration between healers.

On a larger scale, these preliminary findings and lessons from the field highlight the importance of nomenclature. In this post-colonial era, terms such as “tradition” and “convention” must be redefined when examining the healthcare sector of Kenya. If many *waganga* are attempting to *pharmaceuticalize* their industry (encapsulate and mass produce their drugs)—while also advertising through brochures with order forms—then it may be necessary to juxtapose such phenomenological realities with our current notions of convention and modernity. In thinking critically through these tensions and larger notions of healthcare and collaboration, it is our hope that increased coordination will lead to increased quality of care for patients.

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